Uniform Medical Plan

Your health. Your plan. Your choice.

Billing & Administrative Manual

for Hospitals

www.ump.hca.wa.gov

Washington State Health Care Authority

Public Employees Benefits Board

HCA 54-793 (6/08)

Directory

Contact Uniform Medical Plan

Online via secure messaging — **Use the form at www.ump.hca.wa.gov/provider/**

Call Provider Services — **1-800-464-0967**

Customer Service staff available 8 a.m. to 6 p.m. Pacific Time, Monday–Friday

Check Patient Eligibility, Claim Status, Benefits

24-hour automated phone service — **1-800-464-0967**

Customer Service staff available 8 a.m. to 6 p.m. Pacific Time, Monday–Friday

Online at www.ump.hca.wa.gov/provider/ — **Register at www.onehealthport.com**

UMP Publications and News for Providers

Find the following on our Web site at www.ump.hca.wa.gov/provider/

- UMP Fee Schedules
- UMP Billing Manuals
- *UMP Certificate of Coverage* (COC)
- Issues of the *Provider Bulletin*

Update Provider Contact Info, TIN Number

UMP Credentialing/Provider Services — **1-800-292-8092 or 206-521-2023**

See Section 2.3 — **Fax 206-521-2001**

National Provider Identifier (NPI) Number

To submit to UMP or make changes

On our Web site — **www.ump.hca.wa.gov/provider/**

By phone — **1-800-464-0967**

Acupuncturists, Massage Practitioners, Naturopathic Physicians

Healthways WholeHealth Networks — **1-800-274-7526 or 1-800-500-0997**

Medical Review/Preauthorization — 1-800-464-0967 *Fax 425-670-3197*

See Section 4.1.2 for more information on preauthorization of services

Case Management Services — 1-888-759-4855

See Section 4.1.4 for more information on case management services

Prescription Drugs

See Section 9.20 of the Professional Provider manual

Washington State Rx Services **1-888-361-1611**

7:30 a.m. to 5:30 p.m. Pacific Time, Monday–Friday

To request preauthorization of prescription drugs **1-888-361-1611 or Fax 1-800-207-8235**

Mail-Order Pharmacy: Wellpartner **1-800-417-8590**

7:30 a.m. to 5:30 p.m. Pacific Time, Monday–Friday

Faxing in a mail-order prescription **1-866-624-5797**

Must be faxed on provider's letterhead; see Section 9.20 of the Professional Provider billing manual

Calling in a mail-order prescription **1-800-417-8590**

Specialty Prescription Drugs

To find out if a drug is considered a specialty drug, call BioScrip or see the *UMP Preferred Drug List* at **www.ump.hca.wa.gov**

BioScrip **1-877-316-8921**

Electronic Claims Submission

See Section 6.1.1 for more information on submitting claims electronically

Clearinghouse	Setup Information	Troubleshooting Contact
WebMD Now known as Emdeon Business Services (Commercial Connection)	For physician claim services for groups of 10 or less: **1-877-469-3263**	**1-877-469-3263**, press 2 twice
Office Ally	**949-464-9129**, ext 215 Contact person: Lori Kirkland	E-mail **support@officeally.com** Call **949-464-9129**

Electronic Funds Transfer, Electronic Detail of Remittance

To set up these services, call Customer Service at 1-800-464-0967

See Sections 6.1.1.1 and 6.1.1.2

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Section 1

Plan Information

The* UMP Certificate of Coverage *(COC) is the source of plan benefits and coverage information. In particular, see the following sections in the current COC:

- ***Benefits: What UMP Covers* (in particular, see the list of preventive services covered under "Preventive Care")**
- ***Your Prescription Drug Benefit***
- ***Limits on UMP Coverage***
- ***What UMP Doesn't Cover (Expenses Not Covered, Exclusions, and Limitations)***

1.1 Overview of the Uniform Medical Plan (UMP)

The Uniform Medical Plan (UMP) is a self-insured, preferred provider plan for public employees and retirees. It is offered through the Public Employees Benefits Board (PEBB) Program and administered by the Washington State Health Care Authority (HCA).

UMP coverage includes medical, surgical, and obstetric services; chemical dependency and mental health treatment; organ transplants; and prescription drugs. All enrollees have benefits for routine preventive care, vision and hearing examinations, tobacco cessation services, and diabetic education.

1.2 *UMP Certificate of Coverage*

The *UMP Certificate of Coverage* (COC) is the official source of plan benefits and scope of coverage information. Throughout this manual, we reference key information from the COC; however, you should rely on the COC itself for full and complete information regarding scope of coverage and benefit provisions.

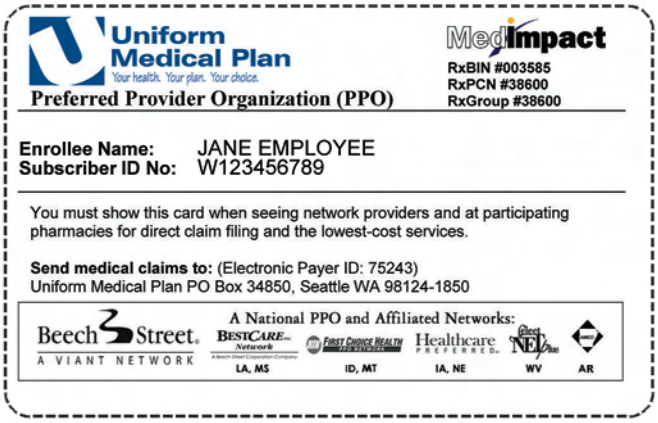
You can find the current UMP COC on the UMP Web site at **www.ump.hca.wa.gov**, or request a copy by calling 1-800-464-0967.

1.3 Approved Provider Types

UMP pays for covered services only when performed by an approved provider type. See the "Approved Provider Types" section of the current COC for a list of provider types approved to deliver services to UMP enrollees.

1.4 Sample Uniform Medical Plan Identification Card

This is the identification card that confirms UMP enrollment. We issue each UMP enrollee an identification card with a unique 9-digit number prefixed by a "W." UMP no longer uses social security numbers for eligibility and claim records. Please use the "W" number on all claims and inquiries.



1.5 Internet-Based Services

1.5.1 The UMP Web Site: www.ump.hca.wa.gov

The UMP Web site has a wealth of information, including a section dedicated to providers. We update our Web site frequently and invite you to take a look. Information available on the Web site includes:

- Current announcements
- *UMP Certificate of Coverage*
- UMP benefits
- Billing manuals
- Fee schedules
- *UMP Preferred Drug List*
- Online provider directory
- The Info Center, an interactive keyword search where you can send feedback to UMP
- National Provider Identifier (NPI) information and submittal form
- Online form to submit name and address changes

1.5.2 Secure Online Portal: OneHealthPort

You can access patient and claims information for enrollees of UMP and several other health plans through OneHealthPort.com. Using this free online service, you can view accurate, up to date information on a secure provider page, including:

- Eligibility effective dates and basic demographics for UMP enrollees.
- Coordination of benefits information to determine if another insurance carrier, including Medicare, is primary for a patient.
- Deductible status (whether the patient has met his or her deductible).
- Detailed claims information, including message codes, to let you know if a UMP claim is in process, if more information is needed, or if a claim has been finalized.
- References and forms for billing and filing claims electronically.
- How to read UMP ID cards.
- UMP's provider directory and a searchable *Preferred Drug List*.
- Secure e-mail to exchange messages containing confidential information with UMP's claims administrator.
- UMP benefits information.

How to Access OneHealthPort

To use the secure provider portal, go to the provider section of the UMP Web site at **www.ump.hca.wa.gov/provider** and select "OneHealthPort Login." You will need to choose an administrator from your organization to manage the organization's account and complete the OneHealthPort registration process, which you can do online. After registration, the administrator will have access to the UMP secure site and information. The designated administrator can then give appropriate staff in the organization their OneHealthPort credentials to access UMP information.

1.6 Interactive Voice Response (IVR)

Available 24 hours a day, 7 days a week; call 1-800-464-0967 to access IVR

You also can use UMP's self-serve telephone system (IVR) to check:

- Patient eligibility and effective date of coverage.
- How much the patient has paid toward his or her medical deductible and annual out-of-pocket limit.
- Claim status.
- For routine ***vision and hearing*** services:
  - If the patient is eligible for an exam.
  - How much of the patient's hardware benefit is available.

To access this information, you will need:

- The provider's tax ID number.
- The enrollee's UMP ID number.
- The enrollee's 6-digit date of birth (mm/dd/yy).

1.7 Administrative Simplification Initiatives

Administrative simplification—reducing the hassle factor, streamlining policies and procedures, and decreasing nonproductive work—continues to be a key focus of UMP.

We have established an internal review process to identify and resolve burdensome administrative policies and procedures. UMP continues to work with other state agencies to develop, implement, and maintain uniform payment methodologies and policies that are consistent with industry standards.

UMP also participates with the Washington Healthcare Forum in their administrative simplification initiatives. The Forum is a coalition of health plans, physicians, hospitals, and purchasers working together to standardize processes among payers. UMP has adopted many of the Forum's policies and guidelines related to claims processing, referral, and prospective reviews. These standard policies and guidelines are posted on the Forum's Web site at **www.wahealthcareforum.org**.

1.8 Annual Deductibles

UMP has two annual deductibles: one that applies to most medical expenses, and one that applies to most prescription drugs. Unless otherwise specified in the current COC, the enrollee must pay the applicable calendar year deductible before the plan will pay for services provided under a given benefit.

The deductibles do not apply to certain services and prescription drugs, such as services covered under the preventive care benefit and generic drugs. Refer to the current COC for more information.

1.9 Plan Payment and Enrollee Responsibility for Network, Non-Network, and Out-of-Area Services

For most services, UMP enrollees can see either network or non-network providers. However, their out-of-pocket costs are typically much higher for services from non-network providers.

Network providers include providers who contract directly with UMP, as well as certain providers in two contracted networks: Healthways WholeHealth Networks and Beech Street. UMP contracts directly with providers in Washington and the Idaho counties of Bonner, Kootenai, Latah, and Nez Perce. Enrollees also have access to network naturopathic physicians, massage therapists, and licensed acupuncturists through the Healthways WholeHealth Networks within Washington State. Outside of Washington State, UMP enrollees should see Beech Street providers to get network-level benefits. Please note that UMP does not use the Beech Street network in Washington State. Beech Street providers in Washington aren't considered "network" providers unless they also contract directly with UMP.

See the UMP online provider directory at **www.ump.hca.wa.gov** to find a network provider.

All other providers are considered **non-network providers**. We pay for services provided by a non-network provider at the non-network rate. If UMP determines that an enrollee did not have access to a network provider, based on the distance from the enrollee's residence to available network providers, we may pay for services as **out-of-area**. See the current COC for a description of distances used in determining out-of-area exceptions.

We calculate benefits based on the UMP **allowed amount**. The allowed amount is UMP's contracted payment rate for the services provided. For professional providers, the allowed amount is

the provider's billed charge or the UMP fee schedule amount, whichever is less. See the complete definition of "allowed amount" in the current COC.

After the enrollee has met the annual medical deductible, we generally pay as follows:

- For **network providers**, we pay at the ***network rate*** (90 percent of the allowed amount for most services). The enrollee pays the remaining 10 percent.
- For **non-network providers:**
  - When the enrollee has access to a network provider but chooses to see a non-network provider, UMP pays at the ***non-network rate*** (60 percent of the allowed amount). The enrollee pays the 40 percent coinsurance and any outstanding balance above UMP's allowed amount.
  - When UMP determines that the enrollee did not have access to a network provider, UMP pays at the ***out-of-area rate*** (80 percent of the allowed amount). The enrollee pays the 20 percent coinsurance and any outstanding balance above UMP's allowed amount.

Refer to the current COC for specific details regarding benefits, enrollee cost-sharing, and scope of coverage.

1.10 Plan Payment After the Enrollee Reaches the Annual Out-of-Pocket Limit

After the enrollee reaches the annual medical out-of-pocket limit (see the current COC for the dollar amount), UMP pays services as follows:

- For covered services by **network providers**, UMP pays 100 percent of the UMP allowed amount; the enrollee pays no coinsurance or copayments.
- For covered services by **non-network providers:**
  - When paid at the ***non-network rate***, UMP pays at 60 percent of the UMP allowed amount; the enrollee must pay both the 40 percent coinsurance and any amount over the UMP allowed amount.
  - When paid at the ***out-of-area rate***, UMP pays 100 percent of the UMP allowed amount. However, the enrollee still must pay the provider any amount over the UMP allowed amount.
- Services for which enrollees must pay even after reaching their annual out-of-pocket limit:
  - Emergency room copayments.
  - Copayments, coinsurance, and ancillary charges for prescriptions filled under the pharmacy benefit.
  - Charges exceeding benefit maximums, limits, and the UMP allowed amount.
  - Services not covered by UMP.
  - Services not preapproved under required case management, if this applies.

Refer to the current *UMP Certificate of Coverage* (COC) for more information about the annual medical out-of-pocket limit.

1.11 Plan Payment to Providers Who "Opt Out" of Medicare

For UMP enrollees with Medicare as their primary coverage, we do not cover or reimburse services rendered under private contracts by providers who "opt out" of the Medicare program. In a private contract situation, the UMP enrollee is solely responsible for the provider's total billed charges. However, in this situation, we make exceptions and pay according to UMP benefits for the following:

- Services provided on an emergency/urgent basis.
- Services that are excluded under the Medicare program, such as routine eye exams and preventive care services/procedures, which will be processed and paid according to UMP benefits.

Section 2

Provider Information

2.1 Provider Network Participation

UMP encourages our enrollees to see network providers through the plan's benefit structure and financial incentives. Enrollees who see non-network providers pay more for their care, often much more. You help your patients avoid higher costs by referring them to other UMP network providers.

***Check a provider's network status at our online provider directory at* www.ump.hca.wa.gov.**

If you routinely refer patients to a non-network provider who would like to become a UMP network provider, he or she may call Provider Services at 1-800-292-8092 or 206-521-2023. All providers must meet UMP credentialing criteria before receiving network provider status.

2.2 Provider Requirements

Uniform Medical Plan network providers agree to comply with the following requirements.

2.2.1 Contracting

Call 206-521-2023 or 1-800-292-8092

- Maintain applicable licensure, registration, and/or certification.
- Maintain professional liability insurance coverage with limits of liability as determined by UMP.
- Meet all credentialing criteria as determined by UMP; these criteria are posted on the UMP Web site.
- Meet any other criteria as stated in the Network Provider Agreement.
- Accept UMP fee schedules and follow UMP policies and procedures.

2.2.2 Billing

Call 425-686-1246 or 1-800-464-0967

- Bill UMP no more than your usual and customary fee.
- Submit claims on either a CMS-1500 or UB-04 claim form within 60 days after providing the covered services. In no instance can a claim be submitted later than 365 days from the date of the covered service(s), except as noted in Section 6.1.3.
- Ensure that enrollees are not billed for any amounts above the maximum allowed amount.
- You cannot always determine the enrollee responsibility at the time of the visit. Therefore, we request that you collect applicable deductibles and coinsurance amounts from UMP enrollees after receiving the detail of remittance showing the enrollee's responsibility.

2.2.3 Referrals and Authorizations

Call 425-686-1246 or 1-800-464-0967

- Refer enrollees to UMP network providers and network facilities, except where no appropriate network provider is available or in case of an emergency.
- See UMP's online provider directory at **www.ump.hca.wa.gov** to search for network providers. You can search this directory by city and provider specialty, or by travel distance from a specified location (such as a ZIP Code). The online directory is updated twice a month. If you notice that your information in the provider directory is not accurate, please call Provider Services at 1-800-292-8092, or send updates through the update form at **www.ump.hca.wa.gov/provider/**.
- UMP does not require referrals for most specialty care. However, the following services must be prescribed by the diagnosing provider; UMP does not cover these services when self-prescribed:
  - Home health and hospice services

- Massage therapy
- Physical, speech, occupational, and neuro-developmental therapy

See the current *UMP Certificate of Coverage* (COC) for specific requirements.

- In addition, some services must be preauthorized to be covered by UMP. See the current COC for a list of services that require preauthorization; see Section 4.1.2 for how to request preauthorization.
- Notify UMP by phone of the hospital admission diagnoses listed in Section 4.1.3.
- See Section 4 of this manual for detailed information about UMP utilization review requirements. In addition, see the current COC, which lists preauthorization requirements, covered benefits, exclusions, and benefit limitations.

NOTE: As of January 1, 2008, UMP requires preauthorization of all inpatient mental health treatment.

2.3 Changes, Additions, and Terminations

Notify UMP of changes to provider status by:

E-mail: umpprovider@hca.wa.gov

Mail: Uniform Medical Plan
PO Box 91118
Seattle, WA 98111-9218

Phone: Toll-free 1-800-292-8092 or
Local 206-521-2023

Fax: 206-521-2001

Web site: **www.ump.hca.wa.gov**

2.3.1 Changes to Provider Information or Status

See below for how to send changes to your information or status to UMP, as well as what information to send.

2.3.1.1 Delegated Providers

Send changes for delegated providers to UMP by e-mail, fax, or mail (see above) quarterly; send only the information that is changing.

2.3.1.2 Solo and Non-Delegated Providers

Notify Provider Services in writing via e-mail, fax, or mail (see above) of any change of a network provider's status—that is, provider name; address change; NPI number; tax ID change; formal or informal disciplinary actions; Medicare sanctions; loss of hospital privileges; loss of malpractice coverage, etc.

2.3.2 Additions

Notify Provider Services as shown below of additions to your practice.

Although UMP is not a closed network, due to administrative resource constraints, we focus on adding new providers in specialties and geographic areas that are critical for enrollee access to care. When we receive a request or application from certain provider types for a non-priority area, we will notify the provider that we will not process the application at that time. We retain applicant information for future consideration. UMP routinely analyzes statewide network adequacy in relation to the location and needs of our enrollees.

However, if your network provider group is adding a new provider, please let us know. We will add new providers even if not in a needed specialty or geographic area, if he or she joins an existing network provider group.

2.3.2.1 Delegated Providers

Additions should be sent to UMP monthly (see contact information above). These may be on a spreadsheet or a Provider Profile, a paper copy or electronic format. If you have any questions about what information is needed, call UMP Provider Services at 1-800-292-8092.

2.3.2.2 Solo and Non-Delegated Providers

Call Provider Services at 1-800-292-8092 to request a new provider application packet. Complete and submit the new provider application/ provider profile as instructed.

2.3.3 Terminations

Notify Provider Services of termination date of a network provider by e-mail, mail, or fax.

Section 3

Enrollee Responsibilities

For enrollee questions:

Customer Service 1-800-762-6004

Prescription drugs 1-888-361-1611

3.1 Enrollee Requirements

Enrollee education is important in ensuring the timely and appropriate payment of health care benefits. We advise UMP enrollees to follow these guidelines when obtaining health care services:

- Choose a provider from the Network Provider Directory as found on the UMP Web site at **www.ump.hca.wa.gov**, or call UMP Customer Service.
- Verify that UMP covers the services they receive by referring to the current *UMP Certificate of Coverage* (COC), or by calling UMP.
- Identify themselves as a UMP enrollee when calling for an appointment.
- Present their identification card at the time they receive services.
- Remind their physician to refer them to UMP network providers and to admit them to UMP network hospitals.
- Request preauthorization from UMP for services listed in the current COC.
- Promptly pay applicable deductibles, coinsurance, copayments, and/or amounts due for noncovered services.

If your patients have questions regarding benefits, network provider status, or payment of their claims, please refer them to UMP at the numbers above.

3.2 Patient's Financial Responsibility

Network providers agree to accept the UMP allowed amount as full compensation for covered services, and agree not to bill enrollees for any amounts above the contracted allowed amount.

Except as provided below or in your network provider agreement, you **can** bill the patient for:

- Any applicable deductible, copayment, or coinsurance.
- Any charges for services specifically excluded in the applicable UMP COC.
- Any charges for services that exceed benefit limits, in the case of benefits with specific visit, day, or dollar limits.

You **cannot** bill the patient for:

- Any amounts above the UMP allowed amount.
- Any supplies or procedures that are included ("bundled") in the UMP allowed amounts for other services.
- Any amounts for which UMP is responsible.
- Any services that UMP determines are not or were not medically necessary, including services we determine are experimental or investigational, unless the services are specific benefit exclusions as listed in the current COC.*

**We will make an exception to this requirement if the patient understood, before receiving the service, that UMP would not cover the specific service, and agreed in writing to assume financial responsibility for the service.*

You cannot always determine the enrollee cost-sharing responsibility at the time of the visit. Therefore, we prefer that you collect applicable deductibles, copayments, and coinsurance amounts from UMP enrollees after receiving the detail of remittance showing the enrollee's responsibility.

Section 4

Utilization Review

To . . .	Call . . .	See . . .
Preauthorize services	1-800-464-0967	Section 4.1.2 or current *UMP Certificate of Coverage*
Notify UMP of hospital admissions	1-800-464-0967	Section 4.1.3
Find eligibility, deductible, and other information		
• Interactive Voice Response (IVR) System	1-800-464-0967	Section 1.6
• OneHealthPort	**www.onehealthport.com**	Section 1.5.2
Determine eligibility *Have subscriber's social security number and press "2" OR call 1-800-464-0967*	Automated toll-free number 1-800-335-1062	

4.1 Requirements

4.1.1 Overview

UMP Medical Review professionals perform utilization and quality review, as well as case management services for our enrollees who are in optional or required case management, or have certain diagnoses (see Section 4.1.3). In addition, UMP may perform retrospective (postpayment) reviews.

The purpose of the review is to determine whether services are medically necessary and delivered in the most appropriate setting. Such reviews help to:

- Monitor quality of care.
- Ensure that treatment is necessary and consistent with good medical practices.
- Discourage unnecessary care.
- Save health care dollars.
- Identify chronic and catastrophic cases appropriate for case management.

4.1.2 Preauthorization

Please see the current *UMP Certificate of Coverage* (COC) for a list of services that UMP requires preauthorization for, or see our Web site at **www.ump.hca.wa.gov**.

4.1.2.1 Procedure for Requesting Preauthorization

Preauthorization requests must come from a provider (although not necessarily the provider who performs the services; for example, the patient's primary care provider could request a surgical procedure that another provider will perform).

To request preauthorization of services, fax the following information to Preauthorization Requests at 425-670-3197. You do not need a form to request preauthorization of services.

- The specific service(s) being requested (use CPT® or HCPCS codes).
- Rationale for medical necessity, including medical records as necessary to establish medical necessity.
- The diagnostic code.
- The patient's name and UMP ID number (beginning with "W").
- The requesting provider's name, phone number, and fax number.

- Who will provide the service(s).
- Date of service.
- Location of service.

If you prefer to mail the information to UMP, send it to the address below. (Please note that this may delay the review and denial or authorization of services.)

Uniform Medical Plan
Preauthorization Requests
PO Box 34578
Seattle, WA 98124-1578

4.1.3 Notification of Hospital Admissions

This program allows UMP to identify patients for whom case management services may be appropriate. Please call UMP case management at 1-888-759-4855 (press option 1) about patients with complex medical conditions like:

- Enrollees who will need additional care (skilled nursing facility or home health care) upon discharge.
- Any hospital stay exceeding 10 days
- Cancer
- Chemical dependency
- Chronic respiratory disease
- Complex mental health diagnosis
- Congenital defects
- Congenital heart disease
- CVA (cerebrovascular accident/stroke)
- Ischemic heart disease/peripheral vascular disease
- Inpatient mental health services
- Neonatal complications
- Neurodegenerative disorders (multiple sclerosis, amyotrophic lateral sclerosis, muscular dystrophy)
- Organ transplant, including stem cell and bone marrow
- Pregnancy (complications only)
- Spinal cord injury
- Trauma (multiple trauma, head injury)

We will evaluate the enrollee's medical condition to determine if he or she needs case management. You do not need to notify us when Medicare or another plan requiring prior notification or preauthorization pays first.

When you notify UMP, this does not mean that the services have been approved for medical necessity or preauthorized. When a service requires preauthorization, you must follow the procedure outlined in Section 4.1.2. In addition, we may still conduct retrospective (postpayment) review (see Section 4.1.6) of admissions for the diagnoses listed above.

4.1.4 Case Management

4.1.4.1 Optional Case Management

Case management is a collaborative process in which a UMP Nurse Case Manager coordinates the care of a UMP enrollee. This case manager will work with all of an enrollee's providers and facilities to ensure that the enrollee receives the best care. We encourage you to contact UMP's case management program for UMP enrollees who need help coordinating their care by calling 1-888-759-4855; press option 1 to refer a patient to case management.

4.1.4.2 Services That Require Enrollment In Case Management

UMP requires case management for patients receiving the following services. Failure to refer the patient to case management before these services are provided may result in denial of coverage.

- Skilled nursing facility admissions
- Rehab unit admissions
- Skilled level homecare and hospice
- All inpatient mental health services
- Bariatric surgery services

4.1.4.3 Case Management as a Condition of Coverage

We may require case management for enrollees whose use of medical services is unsafe, potentially harmful, excessive, or medically inappropriate based on review by the medical director or his or her delegate. Enrollees must follow the case manager's recommendations as a condition for payment of services under UMP.

Among other services, required case management often includes designating a primary provider to coordinate care, and designating a

single hospital and pharmacy to provide covered services or medications. UMP has the right to deny payment for any services received outside the required case management plan, except medically necessary emergency services.

4.1.5 Requirements for Skilled Nursing Facilities (SNF)

Only Medicare-certified facilities are covered by UMP. UMP follows Medicare requirements for skilled nursing care.

Before admission to a skilled nursing facility (SNF), patients must enroll in UMP's case management program and a UMP case manager must preauthorize services.

If a patient has other primary coverage, including Medicare, he or she must notify us to preauthorize care in a SNF before the primary plan's benefits are exhausted, or UMP will not cover anything. Please see the specific benefit limits listed in the current *UMP Certificate of Coverage*, under "Skilled Nursing Facility" in the "Benefits: What UMP Covers" section.

4.1.6 Retrospective Review

We may conduct retrospective (postpayment) review of certain admissions and services. This process involves assessing the:

- Medical necessity of the admission and/or procedure(s) performed.
- Appropriateness of the treatment setting or length of treatment.
- Patient's status upon discharge.
- AP–DRG validation.
- General quality of care delivered.
- Validation of the procedure(s) and diagnosis codes submitted.

Providers and facilities must supply any requested medical records or documentation required to complete these reviews. Failure to comply with such requests may result in denial of payment.

4.1.7 Review Criteria and Quality Screens

UMP Medical Review staff use multiple resources, including Medicare coverage criteria, payment policies, and manuals; and other national guidelines when conducting case reviews. In the majority of cases, UMP follows Medicare coverage and billing guidelines. If Medical Review staff determines that a case does not meet the review criteria, they will refer the case to the UMP Medical Director or Associate Medical Director. The UMP Medical Director or Associate Medical Director, consulting with other medical providers when appropriate, will decide to approve or deny coverage for services or treatments provided. These decisions are based on medical experience and expertise. We will provide medical review criteria used in making a coverage determination upon request.

Section 5

Provider Inquiries, Complaints, Reconsideration Procedures, and Contracting Disputes

Questions? Call Provider Services at 425-686-1246 or 1-800-464-0967

> ***Appeals submitted on behalf of or by an enrollee are handled differently. See the current* UMP Certificate of Coverage *for details.***

UMP has specific procedures for provider inquiries, complaints, and claim reconsideration requests. Definitions for each of these and the procedures follow.

> ***If you have questions about how a claim was processed, see Section 7.2 about claims adjustments.***

5.1 Inquiries

An inquiry is a request for information or for an explanation.

If you have an inquiry such as a question on claims payment status, plan benefits, or enrollee eligibility, please call UMP Provider Services. In most cases, we will answer your question right away.

> ***See Sections 1.5 and 1.6 for other ways to find enrollee information.***

5.2 Complaints

A complaint is an expression of dissatisfaction about:

- Coverage or payment for health care services.
- UMP policies or practices.

To send a complaint, you may contact UMP Provider Services at the above numbers; fax the complaint to 425-670-3197, or write to:

Uniform Medical Plan
PO Box 34578
Seattle, WA 98124-1578

You may also use our online form under "Contact UMP" at **www.ump.hca.wa.gov**. This is a secure system, so you can send confidential information.

5.3 Provider Reconsiderations: Claims

> ***For provider contracting issues, such as network status, contract provisions, or credentialing criteria, see Section 5.4.***

If you just have a question about how we processed a claim or need to submit a corrected claim, please see Section 7.2.

Provider reconsiderations are written requests submitted by a provider asking UMP to reevaluate a previous decision. The request may involve:

- An adverse decision regarding a claim.
- An unresolved claims processing issue, after attempts to resolve with Provider Services.
- A decision to deny, modify, reduce, or terminate payment, coverage, or preauthorization for health care services or benefits.

For network providers, there are three levels of provider reconsiderations.

5.3.1 Level 1 Reconsideration

Level 1 reconsiderations must be submitted within 24 months of your receiving the notice of

action (such as a claim denial or claim processing decision) leading to the request. Send requests to:

Uniform Medical Plan
First-Level Provider Reconsideration
PO Box 34578
Seattle, WA 98124-1578

Include the date of service and indicate clearly the issues you wish us to reconsider. We will assign your request to the appropriate experienced UMP staff, depending on the issue.

You will usually get a response within 30 days. If we approve the reconsideration request, we will send you a Detail of Remittance showing how the claim was paid; if we deny the reconsideration request, we will send you a letter explaining why.

5.3.2 Level 2 Reconsideration

If you do not agree with the Level 1 decision, you may submit a Level 2 reconsideration request to:

Uniform Medical Plan
Second-Level Provider Reconsideration
PO Box 34578
Seattle, WA 98124-1578

Level 2 reconsideration requests must be submitted to UMP within 60 days of the date of the Level 1 determination. Include all of the information that was reviewed at Level 1, a copy of the Level 1 determination, and any other information or documentation you think may be helpful. The Appeals Committee reviews Level 2 reconsiderations. UMP responds to most Level 2 reconsiderations within 30 days of receiving your request.

5.3.3 Level 3 Reconsideration (Hearing)

***Note:** Only network providers may request a Level 3 reconsideration. For non-network providers, the Level 2 determination is the final decision by UMP. We will not accept requests for further review or action.*

A network provider may request a hearing with the Health Care Authority (HCA) Administrator. The HCA Administrator may designate someone to act on his or her behalf, following the same procedures and with the same effect as described below.

This procedure does not apply to issues raised on behalf of enrollees (see the current *UMP Certificate of Coverage* for enrollee appeals procedures). In addition, see Section 5.4 for issues involving contract terminations or credentialing decisions. Disputes will be resolved as quickly as possible.

A. The request for a hearing must:
   - Be in writing and signed by either the provider requesting the hearing or the provider's representative.
   - State the disputed issue(s).
   - Identify the pertinent contract provision(s).
   - State the provider's position on the issues.
   - Confirm that all other contractually available procedures for resolving the issue have been exhausted.
   - Include the name and address of the provider, as well as the name of any person acting on the provider's behalf in the matter of the hearing.
   - Be mailed within 30 days of the date of the letter with UMP's Level 2 determination to:

     Uniform Medical Plan
     Provider Dispute Hearing Request
     PO Box 91118
     Seattle, WA 98111-9218

B. The UMP Director of Operations may provide a written statement stating UMP's position and reasoning, including any information that may be helpful. The UMP must mail this statement to the HCA Administrator and the provider within 20 working days after receipt of the provider's statement.

C. The HCA Administrator or designee will review the written statements and reply in writing to the provider and UMP Director of Operations within 30 working days of receipt of the provider's request. The HCA Administrator may extend this period by notifying all parties.

5.4 Disputes Regarding Your Network Provider Agreement

5.4.1 Professional Providers

Direct all inquiries, complaints, or disputes about the following issues to the UMP Provider Services Manager at 1-800-292-8092:

- Provider contract provisions.
- Credentialing criteria for network participation.
- Termination of network provider participation.
- Approved provider types.

Send your correspondence about these issues to:

E-mail: umpprovider@hca.wa.gov

Mail: Uniform Medical Plan
Provider Services Manager
PO Box 91118
Seattle, WA 98111-9218

5.4.2 Hospitals and Most Facilities

Direct any inquiries, complaints, or disputes about provider contract provisions to the UMP Hospital Reimbursement Specialist at 1-800-292-8092.

Send your correspondence about these issues to:

Uniform Medical Plan
Hospital Reimbursement Specialist
PO Box 91118
Seattle, WA 98111-9218

Section 6

Billing Instructions: General Rules

Questions? Call 206-521-2023 or 1-800-292-8092.

6.1 Claim Submission Procedures

Questions regarding claims submission? Call 425-686-1246 or 1-800-464-0967.

You should submit claims within 60 days of the date of service, but not more than 365 days. We will not process claims initially submitted more than 365 days after the date of service.

We will deny or return claims with missing, inaccurate, or invalid information for you to clarify and resubmit.

Incomplete claims will cause delay or denial of claims payment. We will deny services submitted with invalid procedure, diagnosis, or place of service codes.

6.1.1 Electronic Claim Submission (837s)

Submitting claims electronically helps with reconciling claims processing and payment more easily, and you'll be paid more quickly. See the "Directory" page for the names and contact information for clearinghouses used by UMP for electronic submission of claims. If you are already connected to one of these clearinghouses, submit your UMP claims to payer ID number 75243.

If you currently submit paper claims, we encourage you to contact a clearinghouse for information on submitting claims electronically.

If you're a smaller provider's office, consider submitting electronic claims ***free*** through *Office Ally*. Office Ally is an Internet-based tool that allows providers to directly enter claims through a Web browser or upload a batch file from existing claims data systems. Office Ally checks for correct dates, CPT® codes, and ICD-9-CM codes before sending your claims to UMP. You'll receive e-mail confirmation and feedback on incomplete claims within 24 hours. Your practice will be paid faster and the service is free!

You can register by selecting Office Ally on the OneHealthPort Web site at **www.onehealthport.com**. Use UMP's payer ID number 75243 when submitting claims. If you have trouble registering, call Office Ally customer support at 949-464-9129.

Office Ally also offers a free, online practice management tool that complements the online billing service. For more information, visit **www.officeally.com**.

6.1.1.1 Electronic Funds Transfer (EFT)

Electronic Funds Transfer (EFT) is a free service available to network providers. Through this service, UMP deposits payments for claims directly into your organization's bank account instead of mailing a check. You'll receive payment more quickly with EFT. If you want to receive your payments from UMP through EFT, please send UMP a secure e-mail through your UMP provider portal account (set up via **www.onehealthport.com**). Once connected to the portal, select the Electronic Funds Transfer link and follow the easy instructions on how to send a secure e-mail. You also may call UMP Provider Services at 1-800-464-0967 to request the forms to set up EFT.

6.1.1.2 Electronic Remittance Advice (835s)

UMP can send an electronic remittance advice (called an 835). Unless the claim requires a special review, you will receive an electronic notice of how we processed the claim 5-7 days after we receive it. By contrast, it can take up to 15 days to receive a detail of remittance (DOR) using the current paper process.

If you use electronic funds transfer (EFT), you'll get paid at about the same time you receive the 835 (no more than 2 days lag time). However, you can receive 835s electronically even if you don't choose to sign up for EFT.

Call UMP Provider Services at 1-800-464-0967 or send us a secure e-mail through your OneHealthPort account to find out how to sign up to receive 835s.

6.1.2 Paper Claim Submission

Mail paper claims to UMP at:

Uniform Medical Plan
PO Box 34850
Seattle, WA 98124-1850

Professional providers must use the 8/05 revision of the CMS-1500 claim form.

Hospitals and most facilities bill with the UB-04 form.

6.1.3 Timely Submission of Claims

You should submit claims for covered services within 60 days of the date of service or discharge, but not more than 365 days. UMP will not process claims submitted more than 365 days after the date of service or discharge. Under exceptional circumstances, such as when UMP is secondary and the primary payer has not paid on a timely basis, we may waive this provision.

To request a waiver, send an explanation in writing to:

Manager, Customer Service
Uniform Medical Plan
PO Box 34850
Seattle, WA 98124-1850

6.2 Coordination of Benefits (COB)

Mutual of Omaha electronically transmits Medicare claims information for Medicare-enrolled UMP enrollees directly to UMP for secondary payment. This includes Medicare claims processed by Noridian Administrative Services and other Medicare contractors. Therefore, you or your UMP patients usually do not need to send UMP paper claims and copies of the Explanation of Medicare Benefits or Medicare Summary Notice.

For all other claims where UMP pays secondary, you must submit a copy of the original claim form and enrollee Explanation of Benefits (EOB) and/or Detail of Remittance (DOR) from the primary payer to UMP for secondary payment.

When UMP pays secondary to another group medical insurance plan, we base reimbursement for services on standard coordination of benefits. This means that, after the enrollee pays the annual deductible, UMP plus the enrollee's other coverage combined pay up to 100 percent of the allowed amount (but not more than 100 percent). Usually, enrollees who have UMP as their secondary coverage pay no enrollee cost-share on most claims unless they have not paid the annual deductible.

For other services, here's how it works when UMP is not the primary payer:

- The primary payer pays a portion of the bill and sends the enrollee an Explanation of Benefits (EOB).
- The enrollee sends a copy of the bill and the EOB to UMP, or asks the provider to do so.
- UMP reviews the primary plan benefit calculation, and the primary plan payment.
- UMP determines what the normal benefit would have been if UMP had been the only payer.
- UMP compares allowed amounts and determines which is the highest allowed amount.
- UMP pays the difference between the highest allowed amount and the primary plan's payment, up to the normal UMP benefit amount.

Here's an example to show the process and terms above. This example assumes that the primary plan ordinarily pays 80 percent of the allowed amount after a $500 deductible.

Provider's charge	**$1,200**	
Primary Plan Benefit Calculation		
Primary plan's allowed amount	$1,000	
Primary plan deductible (enrollee pays to provider)	$500	
Primary plan pays	$400	(80% of $500 balance)
UMP Benefit Calculation		
UMP allowed amount	$900	
UMP deductible (enrollee pays to provider)	$200	
UMP normal benefit	$630	(90% of $700 balance)
Actual Payment by UMP PPO		
Highest allowed amount	$1,000	(primary plan)
Primary plan's payment	$400	
UMP pays	***$600***	

6.3 Audit and Right of Recovery Policy

We have the right to audit, inspect, and duplicate records maintained on enrollees by our network providers, as stated in the contract between UMP and the provider.

Please notify us of any overpayments or underpayments promptly. Our right to seek prompt refund from you for any duplicate, excess, or otherwise erroneous payments, or to deduct the amount overpaid from future payments and take other actions, is also in the contract between UMP and the provider.

6.4 Detail of Remittance (DOR)

See Section 6.1.1.2 on how to get remittance advice electronically (835s).

Providers will receive a Detail of Remittance (DOR) from UMP, which shows how much we pay for each claim. You can find DOR samples for UMP in the appendices at the end of this manual.

The DOR identifies the patient by:

- Name
- Identification number
- The claim number assigned by the claims administrator

For each service line of the claim, the DOR lists:

- Service date
- Procedure code of the service (or revenue code, for hospitals)
- Submitted charges
- Allowed amount
- Noncovered charges
- Message code(s)
- Deductible/copay/coinsurance amounts (patient responsibility)
- Network provider discounted amount
- Patient balance
- Amount paid by UMP

For quicker communications, providers may choose to receive DORs electronically from UMP through selected clearinghouses. Through this payment option, your organization doesn't have to wait for mail delivery of a paper DOR. For more information, please contact UMP toll-free at 1-800-464-0967 or locally at 425-686-1246.

6.5 Explanation of Benefits (EOB)

When we pay a claim, we send the patient an Explanation of Benefits (EOB) that shows the original submitted charges, any noncovered charges, the patient's responsibility, and the amount UMP paid. You can find a sample of the EOB for UMP in Appendix 3 of the Professional Provider manual.

The patient's EOB will also show the provider's charges that exceed the UMP allowed amount. The patient is not responsible for these charges and you cannot bill the patient for them.

6.6 Patients' Rights to Confidentiality

You must keep audit, billing, payment, medical, and other patient-related information for UMP enrollees confidential, except as stated in the contract between UMP and the provider, or unless required by law. You can find our Notice of Privacy Practices on the UMP Web site, or request a hard copy by calling 1-800-464-0967.

Section 7

Billing Instructions: Hospitals

7.1 Instructions for Completing the UB-04 Claim Form

Hospitals must submit facility charges on the UB-04 claim form (or the electronic equivalent) for payment consideration. See page 3 of this section for a sample form. The descriptions in the table below show what to enter in each field. Missing or inaccurate information may result in denied or delayed processing of claims.

Leave "grayed out" items blank.

UB-04 Form Locator	Description
01	Billing Provider Name, Address, and Telephone Number
02	Pay-to Name and Address
03a	Patient Control Number
03b	Medical Record Number
04	Type of Bill
05	Federal Tax Identification Number
06	Statement Covers Period
07	Reserved for Assignment by the NUBC
08	Patient Name/Identifier
09	Patient Address
10	Patient Birth Date
11	Patient Sex
12	Admission/Start of Care Date
13	Admission Hour
14	Priority (Type) of Visit
15	Source of Admission/Point of Origin
16	Discharge Hour
17	Patient Discharge Status
18–28	Condition Codes
29	Accident State
30	Reserved for Assignment by the NUBC
31–34	Occurrence Codes and Dates
35–36	Occurrence Span Codes and Dates
37	Reserved for Assignment by the NUBC
38	Responsible Party Name and Address
39–41	Value Codes and Amounts
42	Revenue Codes
43	Revenue Description
44	HCPCS/Accommodation Rates/HIPPS Rate Codes
45	Service Date
46	Service Units
47	Total Charges
48	Non-Covered Charges
49	Reserved for Assignment by the NUBC
50	Payer Name
51	Health Plan Identification Number
52	Release of Information Certification Indicator
53	Assignment of Benefits Certification Indicator
54	Prior Payments—Payer
55	Estimated Amount Due—Payer
56	National Provider Identifier (NPI Number)—Billing Provider
57	Other (Billing) Provider Identifier
58	Insured's Name
59	Patient's Relationship to Insured
60	Insured's Unique Identifier
61	Insured's Group Name
62	Insured's Group Number
63	Treatment Authorization Code
64	Document Control Number (DCN)
65	Employer Name (of the Insured)
66	Diagnosis and Procedure Code Qualifier (ICD Version Indicator)

UB-04 Form Locator	Description
67	Principal Diagnosis Code (1-7) and Present on Admission (POA) Indicator (position 8)
67A–Q	Other Diagnosis Codes
68	Reserved for Assignment by the NUBC
69	Admitting Diagnosis Code
70a–c	Patient's Reason for Visit
71	Prospective Payment System (PPS) Code
72a–c	External Cause of Injury (ECI) Code
73	Reserved for Assignment by the NUBC
74	Principal Procedure Code and Date
74a–e	Other Procedure Codes and Dates
75	Reserved for Assignment by the NUBC
76	Attending Provider Name and Identifiers
77	Operating Physician Name and Identifiers
78–79	Other Provider (Individual) Names and Identifiers
80	Remarks Field
81	Code—Code Field

Note: Use the CMS-1500 form for billing professional services. Instructions for completing the CMS-1500 form are in the *UMP Billing & Administrative Manual for Professional Providers*.

1	2	3a PAT. CNTL #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH
			7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

CONDITION CODES

	31 OCCURRENCE CODE	31 OCCURRENCE DATE	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE SPAN CODE	35 OCCURRENCE SPAN FROM	35 OCCURRENCE SPAN THROUGH	36 OCCURRENCE SPAN CODE	36 OCCURRENCE SPAN FROM	36 OCCURRENCE SPAN THROUGH	37
a															a
b															b

38		39 VALUE CODES CODE	39 VALUE CODES AMOUNT	40 VALUE CODES CODE	40 VALUE CODES AMOUNT	41 VALUE CODES CODE	41 VALUE CODES AMOUNT
	a						
	b						
	c						
	d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23		***PAGE _____ OF _____***	***CREATION DATE***		***TOTALS***				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI		
A							57		A
B							OTHER		B
C							PRV ID		C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A					A
B					B
C					C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			A
B			B
C			C

66 DX	67	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

80 REMARKS	81CC a		
	b		
	c		
	d		

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

7.2 Process for Resubmission or Adjustment of Claims

7.2.1 Request for Adjustment of Previously Processed Claim

If you believe we processed a claim incorrectly, please call UMP Provider Services at 1-800-464-0967.

If we agree, we will reprocess the claim. However, you may need to resubmit a corrected claim with supporting documentation and reason why the claim should be adjusted. You will receive a corrected Detail of Remittance (DOR) or 835, as well as any additional payment owed to you.

We will not pay for any adjustments requested more than 24 months after we paid the claim. If the adjustment request involves coordination of benefits, the time limit is 30 months.

If you question whether UMP processed a claim correctly and we do not agree to reprocess it, you may submit a reconsideration (see Section 5.3).

7.2.2 Submitting a Corrected Claim

7.2.2.1 Submitting Corrected Claims Electronically (Hospitals Only)

To submit adjusted hospital claims to UMP electronically:

- On the UB-04 form, change the third digit in the "Type of Bill" field (Form Locator 4) to "7" (xx7).
- In the "Remarks" field (Form Locator 84), explain why the claim needs adjustment.

Note: If you don't change the third digit to 7 in the Type of Bill field, we will deny the claim as a duplicate.

If you have any questions, please contact UMP Provider Services at 1-800-464-0967.

7.2.2.2 Submitting Corrected Claims By Fax or Mail

***To submit a corrected claim by fax or mail, you MUST use the Corrected Claim Cover Sheet in Appendix 1. This form is also on the UMP Web site at* www.hca.wa.gov/provider/claimsub.shtml.**

If you don't send a completed Corrected Claim Cover Sheet along with your corrected claim, UMP may deny the claim as a duplicate. Write on the claim form, fax sheet, or attached letter what you are correcting and the reason the claim should be adjusted. Include additional information only if UMP asks for it.

Send the corrected claim, cover sheet, and any additional documentation or information, to:

Mail: Uniform Medical Plan
PO Box 34850
Seattle, WA 98124-1850

Fax: 425-670-3197

If you have questions about submitting a corrected claim, call UMP Provider Services at 1-800-464-0967.

Note: UMP expects providers to bill accurately for services. Changing procedure or diagnostic codes or modifying records for the sole purpose of gaining additional payment from UMP, and not to correct an error, is inappropriate and may trigger an investigation.

If you question whether a claim was processed correctly and Provider Services does not agree, you may file a request for a reconsideration. See Section 5.3 in this manual for the procedure.

7.3 Interim Claims Policy

UMP does not accept interim claims for inpatient admissions. We accept only "admit through discharge claims" ("1" in Form locator 4, frequency code, UB-04) for payment consideration.

We will return UB-04 claim forms with any of the following entered in Form locator 4 (Type of Bill):

- "30 Still Patient" in Form locator 17 (Patient Discharge Status) and/or a
- "2 Interim—First Claim"
- "3 Interim—Continuing Claim"
- "4 Interim—Last Claim"

Under exceptional circumstances of hardship, a hospital may appeal to UMP to waive this policy on a case-specific basis. To request a waiver, contact:

Mail: **Uniform Medical Plan**
Medical Review
Attn: Reconsiderations
PO Box 34578
Seattle, WA 98124-1850

Phone: 1-800-464-0967

7.4 Coding Information

UMP recognizes UB-04 claims data elements as defined by the National Uniform Billing Committee (NUBC). Standard UB-04 revenue codes are required on all service lines of a claim.

The most appropriate (based on the date of service) versions of the ICD-9-CM diagnosis and procedure codes or CPT®/HCPCS codes are required for billing purposes. The American Medical Association (AMA) and Medicare add and revise the diagnosis and procedure codes. The updated codes must be used for UMP claims when the codes become valid for use with Medicare claims.

We edit all diagnosis and procedure codes on the claim form for validity and accuracy using the Medicare Inpatient Code Editor or Outpatient Code Editor, as applicable. We will deny incomplete claims and services submitted with invalid procedure or diagnosis codes.

For inpatient cases not reimbursed on an AP-DRG per-case or per diem basis, we use a semi-private room rate to determine the allowed amount. We may pay for private rooms (revenue codes 111–119 and 141–149) when determined medically necessary.

7.4.1 Outpatient Modifiers

UMP recognizes the following CPT® and HCPCS modifiers on the UB-04 for outpatient use:

Modifier	Description
25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service
27	Multiple Outpatient Hospital E/M Encounters on the Same Date
50	Bilateral Procedure
52	Reduced Services
58	Staged or Related Procedure or Service by the Same Physician During the Postoperative Period
59	Distinct Procedural Service
73	Discontinued Out-Patient Procedure Prior to Anesthesia Administration
74	Discontinued Out-Patient Procedure After Anesthesia Administration
76	Repeat Procedure by Same Physician
77	Repeat Procedure by Another Physician
78	Return to the Operating Room for a Related Procedure During the Postoperative Period
79	Unrelated Procedure or Service by the Same Physician During the Postoperative Period
91	Repeat Clinical Diagnostic Laboratory Test
LT	Left side (used to identify procedures performed on the left side of the body)
RT	Right side (used to identify procedures performed on the right side of the body)
E1	Upper left, eyelid
E2	Lower left, eyelid
E3	Upper right, eyelid
E4	Lower right, eyelid

Modifier	Description
FA	Left hand, thumb
F1	Left hand, second digit
F2	Left hand, third digit
F3	Left hand, fourth digit
F4	Left hand, fifth digit
F5	Right hand, thumb
F6	Right hand, second digit
F7	Right hand, third digit
F8	Right hand, fourth digit
F9	Right hand, fifth digit
GG	Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day
GH	Diagnostic mammogram converted from screening mammogram on same day
LC	Left circumflex, coronary artery (use with codes 92980–92987, 92995, 92996)
LD	Left anterior descending coronary artery (use with codes 92980–92987, 92995, 92996)
RC	Right coronary artery (use with codes 92980–92987, 92995, 92996)
QM	Ambulance service provided under arrangement by a provider of services
QN	Ambulance service furnished directly by a provider of services
TA	Left foot, great toe
T1	Left foot, second digit
T2	Left foot, third digit
T3	Left foot, fourth digit
T4	Left foot, fifth digit
T5	Right foot, great toe
T6	Right foot, second digit
T7	Right foot, third digit
T8	Right foot, fourth digit
T9	Right foot, fifth digit

7.4.2 Revenue Code Billing Instructions for Outpatient Claims

UMP accepts the following revenue codes on an outpatient facility claim without a corresponding CPT® code or HCPCS level II code. When reimbursed under the Outpatient Prospective Payment System (OPPS) APC methodology, UMP considers these to be packaged services, and will not pay for them separately. However, we include the cost of these services in determining outlier payments.

Revenue Code	Description
250	Pharmacy—General Classification
251	Pharmacy—Generic Drugs
252	Pharmacy—Non-Generic Drugs
253	Pharmacy—Take-Home Drugs
254	Drugs Incident to Other Diagnostic Services
255	Drugs Incident to Radiology
257	Non-Prescription Drugs
258	IV Solutions
259	Other Pharmacy
260	IV Therapy—General Classification
262	IV Therapy/Pharmacy Services
263	IV Therapy/Drugs/Supply Delivery
264	IV Therapy/Supplies
269	Other IV Therapy
270	Medical—Surgical Supplies
271	Non-Sterile Supply
272	Sterile Supply
274	Prosthetic/Orthotic Devices
275	Pacemaker
276	Intraocular Lens
277	Oxygen—Take Home
278	Other Implants
279	Other Supplies/Devices

Revenue Code	Description
280	Oncology—General Classification
289	Other Oncology
290	Durable Medical Equipment
343	Diagnostic Radiopharms
344	Therapeutic Radiopharms
370	Anesthesia—General Classification
371	Anesthesia—Incident to Radiology
372	Anesthesia—Incident to Other Diagnostic Services
379	Other Anesthesia
390	Blood—General Classification
399	Other Blood Storage and Processing
560	Medical Social Services—General Classification
569	Medical Social Services—Other Medical Social Services
621	Supplies Incident to Radiology
622	Supplies Incident to Other Diagnostic Services
624	Investigational Device (IDE)
630	Drugs Requiring Specific Identification, General Class
631	Single Source
632	Multiple
633	Restrictive Prescription
681	Trauma Response Level I
682	Trauma Response Level II
683	Trauma Response Level III
684	Trauma Response Level IV
689	Trauma Response Other
700	Cast Room—General Classification
709	Other Cast Room
710	Recovery Room—General Classification
719	Other Recovery Room
720	Labor Room/Delivery—General Classification
721	Labor
762	Observation Room
810	Acquisition of Body Components
819	Other Donor

For all other revenue codes, use the applicable CPT® or HCPCS procedure code(s) on a hospital outpatient facility claim.

7.4.3 Type of Bill

Type of Bill (Form locator 4 UB-04) indicates the type of facility and bill classification (inpatient, outpatient, etc.) specific to a claim. UMP uses this required field to process claims. For appropriate Type of Bill usage, please refer to the National Uniform Billing Committee Data Specifications Manual for the UB-04.

7.4.4 Outpatient Line Item Dates of Service

UMP requires line item dates of service on all outpatient hospital facility bills for each line where a CPT® or HCPCS procedure code is required. This includes claims where the "from" and "through" dates are the same. Omission of these dates will delay processing.

7.4.5 Service Units

UMP defines a service unit as the number of times a service or procedure was performed per the CPT®, HCPCS, or Revenue Code definitions. Providers must not report multiple units on the claim form for any procedure code where it is not supported by these definitions.

7.4.6 Repetitive Services

Follow Medicare billing guidelines for repetitive services.

7.4.7 Outpatient Code Editor (OCE) Edits

UMP follows Medicare guidelines and applicable versions of the Outpatient Code Editor (OCE), updated quarterly. UMP recognizes that some Medicare inpatient-only procedures may be appropriate in an outpatient setting. We will reimburse hospitals for those services according to the payment addendum of your Network Provider Agreement for Hospitals.

7.4.8 Outpatient Observation Billing Policy

Hospitals billing for observation must follow Medicare billing policy. UMP follows Medicare coverage criteria when determining whether observation services are eligible for separate APC reimbursement. UMP calculates observation services eligible for separate reimbursement using a single unit.

7.4.9 Outpatient Services Reimbursed on the Professional Fee Schedule

UMP reimburses some outpatient services based on the Technical Component of the UMP Professional Fee Schedule. Your Hospital Payment Addendum identifies all services reimbursed in this way. Payment is the lesser of billed charges or the Technical Component Fee Schedule Amount.

Section 8

Reimbursement: Hospitals

8.1 Hospital Reimbursement

Payment rates are specified in the contract between the hospital and UMP. We pay inpatient claims using the rates in effect on the date of discharge and outpatient using the date of service.

For inpatient hospital claims, UMP's benefits apply based on the patient's admission date. This includes determination of covered services, deductibles, copayments, and provider status (for example, network or non-network). If the network provider status ends while an enrollee is hospitalized, payment is based on the contractual arrangement in effect at time of admission.

8.1.1 Inpatient Reimbursement for Hospitals

UMP bases its reimbursement for inpatient hospital payment on the All-Patient Diagnosis Related Group (AP-DRG) system.

The applicable AP-DRG relative weight is multiplied by the hospital-specific conversion factor. For outlier information, refer to Section 9.4 of this manual.

AP-DRG Relative Weight: AP-DRGs are weighted, and measure related types of patients treated to the costs incurred by the hospital. The current weight table is available on our Web site at **www.ump.hca.wa.gov**.

Conversion Factor: The conversion factor is a dollar amount, specific to each hospital. The conversion factor is developed from an initial base rate that represents statewide average operating costs per case. The initial base rate is hospital-specific based on capital expenditures, area wage differences, direct and indirect teaching costs, increased resources required to treat low-income patients, margin, uncompensated care, and inflation.

Exceptions to AP-DRG pricing include the hospitals identified in Section 8.1.2, specialized providers (such as cancer research centers), and the following categories of cases:

- **Psychiatric** (424–432), **Chemical Dependency** (743–751), and **Rehabilitation** (462) AP-DRGs, which are reimbursed on a hospital-specific tiered per diem basis.
- **Low-volume AP-DRGs.** These include AP-DRGs identified as Low Volume on the UMP weight table (see the UMP Web Site).
- **Transplant Cases** (except cornea). UMP pays transplant AP-DRGs 103 (Heart), 302 (Kidney), 480 (Liver), 795 (Lung), 803–804 (Allogeneic Bone Marrow), 805 (Simultaneous Kidney/Pancreas), and 829 (Pancreas) based on a percentage of charges specific to the hospital. UMP pays all other transplants under regular AP-DRG reimbursement. Transplants are subject to preauthorization.
- **Transfer Out Cases**. UMP pays the lesser of the AP-DRG Inlier Amount (plus high cost add-on payment, if applicable) or the Percent of Charge Rate (EPOC). Transfer out cases are identified by discharge status codes of: 02 (Transfer to an acute care hospital), 05 (to another type of institution for inpatient care), 62 (Inpatient Rehab Facilities), or 63 (Medicare Certified Long-Term Care Hospital).
- **Discharged Same-Day Live Cases.** UMP pays the lesser of the AP-DRG Inlier Amount or the Percent of Charge Rate (EPOC). These are identified by admit and discharge on the same day and discharge status is not 20 (Expired). UMP pays AP-DRGs 620, 629 (Normal Newborn), and 373 (Normal Vaginal Delivery) under regular AP-DRG reimbursement.
- **Left Against Medical Advice.** UMP pays the lesser of AP-DRG Inlier Amount or the Percent of Charge Rate (EPOC). These are identified by discharge status 07 (Left Against Medical Advice).
- **Low Charge Outlier Cases.** UMP pays at the Percent of Charge Rate (EPOC). These are identified when covered charges are less than the

low charge outlier threshold for the AP-DRG on the UMP weight table (see UMP Web site).

- **High Cost Outlier Cases.** UMP pays the AP-DRG Inlier amount, plus costs above the threshold. See Section 9.4 for threshold definition and how to identify a high cost outlier case.
- **Subacute Services.** You must receive preauthorization from UMP, and UMP's case management program must designate these services as subacute. These services include Skilled Nursing, Transitional Care Units, Intermediate Care Units, Hospice, and similar units. UMP pays using a specified percent of charges located in the hospital payment addendum.

8.1.1.1 Leapfrog and COAP Participation

In 2007, UMP implemented a pay-for-performance program using Leapfrog Hospital Quality and Safety survey results and COAP (Clinical Outcome Assessment Program) participation for the AP-DRG per case hospitals.

The Uniform Medical Plan is providing hospitals the opportunity to gain up to a 4 percent increase in their AP-DRG Inpatient Conversion Factor.

Category	Incentive
Participation	1% increase in the inpatient conversion factor if listed as participating by both Leapfrog and (if applicable) COAP.
Leapfrog's "Leap 1": Computerized Physician Order Entry	1% increase in the inpatient conversion factor if the entire circle is filled in (incentive provided for full implementation only).
Leapfrog's "Leap 2": ICU Physician Staffing (IPS)	1% increase in the hospital conversion factor if the entire circle is filled in (incentive provided for full implementation only).
Leapfrog's "Leap 4": Safe Practices Score	One quarter percent increase provided for each quarter of the circle filled in, up to a maximum of 1% increase in the inpatient conversion factor for full compliance with the Leapfrog standard.
Total	*4% increase offered to hospitals*

We update these incentives on a biannual basis as needed. Refer to your hospital payment addendum for further information about incentive payments.

8.1.1.2 Never Events

UMP has adopted a "Never Event" policy. UMP will not provide payment to a facility where a UMP enrollee has experienced a Never Event while staying at the facility. The National Quality Forum (NQF) defines a Never Event as: "errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a health care facility." UMP will use the current listing of the NQF Never Events, found on **www.qualityforum.org** under Serious Reportable Events. When a Never Event occurs, the hospital agrees to waive all costs associated with the Never Event, UMP will not provide payment, and the patient is not responsible for payment. The hospital will notify UMP should a Never Event occur.

8.1.2 Inpatient Reimbursement for Low-Volume, Critical Access, and Children's Hospitals

UMP has defined a set of low-volume, critical access, and children's hospitals to which per-case reimbursement does not apply. We reimburse these hospitals based upon a medical or surgical per diem rate. The reimbursement is determined by multiplying the applicable per diem rate (medical or surgical) by the length of stay for the case. The applicable per diem rate is determined by classifying a case into an AP-DRG, each of which is categorized as either medical or surgical.

8.1.3 Outpatient Reimbursement

UMP pays for outpatient Services in one of three ways, depending on the type of hospital and the type of service provided:

- Medicare Ambulatory Payment Classification (APC) methodology
- Percentage of the allowed amount
- Rates on the UMP *Professional Provider Fee Schedule*

Please refer to the payment addendum of your Network Provider Agreement for Hospitals for more information.

We determine APC Reimbursement by multiplying the weight by the outpatient conversion factor listed in the hospital payment addendum.

APC Relative Weights: The UMP uses the same weights as published by Medicare during the same time period.

Conversion Factor: The conversion factor is a dollar amount specific to each hospital; please refer to your hospital payment addendum for the conversion factor.

UMP uses Medicare's Outpatient Code Editor (OCE) to process Outpatient APC claims.

APC reimbursement methodology does not apply to the following hospitals:

- Children's hospitals
- Critical access hospitals
- Low-volume hospitals
- Psychiatric hospitals
- Rehabilitation hospitals
- Rural hospitals

Section 9

Plan Payment

For services not listed in the billing manual, please reference the current *UMP Certificate of Coverage* (COC) or call 1-800-464-0967 for coverage guidelines and restrictions.

9.1 Hospital Inpatient Stay Definition

We define an inpatient stay as an enrollee's admittance to a hospital that incurs room and board services for an expected duration of 24 hours or longer.

The AP-DRG payment amount includes all preadmission, diagnostic, appliance, pharmaceutical, operative, treatment, and room and board charges for the patient, beginning one calendar day before the date of admission and extending through date of discharge.

If the hospital has an ambulatory surgery program or a "day patient" program where an enrollee receives services which require a hospital stay of less than 24 hours, you must bill the services as outpatient.

9.2 Non-Covered Revenue Codes

Charges for the following services should be listed as noncovered (Form locator 48), and are generally not considered for payment.

Revenue Code	Description
180–189	Leave of Absence
220[1]	Special Charges
256	Experimental Drugs
257	Pharmacy—Non-Prescription
399	Other Blood Storage and Processing
540–549	Ambulance
624	Medical/Surgical Supplies FDA Investigational Devices
670	Outpatient Special Residence Charges
723	Labor Room/Delivery Newborn Circumcision
810–812, 819	Acquisition of Body Components
941	Recreational Therapy
942[2]	Education/Training (see exception below regarding Diabetes Education)
949	Other Rx Svcs/Weight Loss
960–989[3]	Professional Fees
990–999	Patient Convenience Items

[1] *Revenue code 220 (Special Charges) requires submittal of additional information identifying and justifying the charges.*

[2] *For revenue code 942 (Education/Training), UMP provides benefits for Medicare-approved diabetes education programs and follows Medicare protocol and criteria.*

[3] *Revenue Codes 960 through 989 (Professional Fees) are generally not covered when billed on a UB-04 form. Bill these services with the appropriate CPT®/HCPCS level II code on a CMS-1500 form or electronic equivalent. We will consider professional services separately if submitted on a CMS-1500 form; covered charges will be paid using the UMP* Professional Provider Fee Schedule.

9.3 Services Prior to Admission

AP-DRG per-case facilities can consider all services provided within one calendar day prior to admission as part of the admission and covered by AP-DRG reimbursement. This includes, but is not limited to radiology, pathology, and emergency room services. Any charges for services on the calendar day before admission must be submitted on the inpatient UB-04 bill and not billed separately as an outpatient service. The Statement Covers Period (Form locator 06 on the UB-04) must reflect the admission date (from) and discharge date (through).

9.4 Cost Outliers: Inpatient Claims

Outlier claims are those claims with unusually high or low costs. Catastrophic losses for which a hospital may be at risk are the major focus of UMP's outlier policy.

9.4.1 High Cost Outliers

UMP's high cost outlier payment methodology applies to cases where the costs exceed a specific outlier threshold, as defined in the payment addendum of the hospital contract.

Definitions

- **Inlier Amount**—The allowed charge for the specific AP-DRG which the claim is grouped to.
- **Estimated Percentage of Charges** (EPOC)—Defined in the payment addendum of the hospital contract.
- **Allowed Charges**—Billed charges minus any charges for non-covered revenue codes identified in Section 9.2 of this billing manual.
- **Threshold**—The dollar amount or percentage of inlier amount (whichever is greater) specified in the payment addendum of the hospital contract.

  High cost outlier calculation:

  Cost=Covered Charges x EPOC

To determine a high-cost outlier case, the cost outlier add on (adjusted charges minus final cost outlier threshold) must be greater than $0. See example below.

	Explanation	Amount
1.	Claim's charges	$72,419.16
2.	Hospital's EPOC	40%
3.	Adjusted charges (line 1 x line 2)	$28,967.66
4.	Inlier Amount	$27,872.89
5.	Factor for cost outlier threshold #1	2.0
6.	Cost outlier threshold #1 (line 4 x line 5)	$55,745.78
7.	Fixed cost outlier threshold	$30,000
8.	Final cost outlier threshold (greater of line 6 or line 7)	$55,745.78
9.	Cost outlier add-on (max 0, line 3 – line 8)	$0

In the example above, this claim does not meet the criteria for a high-cost outlier.

9.4.2 Low Charge Outliers

UMP's low charge outlier payment methodology applies to cases where the allowed charges are less than the low charge outlier threshold for the AP-DRG on the UMP weight table. In these situations, we reimburse these claims at the estimated percent of charges (EPOC).

9.5 Timely Filing and Late Claims

You should submit claims for covered services within 60 days of the date of service or discharge. You ***must*** submit claims within 365 days of providing services. UMP will not process claims submitted more than 365 days after the date of service or discharge. A hospital cannot seek payment from enrollees or the UMP for covered services for which the hospital did not properly bill within 365 days after providing the services.

We define late claims as those submitted by the hospital after the original claim. These claims are identified by a "5" entered in Form locator 4 (Type of Bill), 3rd digit, of the UB-04 form.

For claims paid on an AP-DRG or per diem basis, we will deny all late claims and notify the hospital that the case was paid in full under the AP-DRG or per diem payment system.

If the original claim was submitted incorrectly or needs to be adjusted, submit a corrected claim with "7" as the third digit in Field 4, Type of Bill (xx7), and we will process it accordingly.

9.6 Transfers: Inpatient Claims

Network Hospital Paid Under AP-DRG Methodology: We pay for patient transfers to another hospital based on the AP-DRG payment amount or the hospital's contracted percentage (EPOC) of allowed charges, whichever is less. These cases are commonly referred to as transfer-out cases, and are defined on the UB-04 by any of the following codes entered in Form locator 17 (Patient Discharge Status):

- 02 (Transfer to an acute care hospital).
- 05 (to another type of institution for inpatient care), 62 (Inpatient Rehab Facilities).
- 63 (Medicare Certified Long-Term Care Hospital).

Exceptions to the above payment policy are for AP-DRG 456 (Burn Transfer), and AP-DRGs 639 and 640 (Neonate Transfers). We pay these at the AP-DRG payment amount or as low-volume AP-DRGs, whichever is appropriate.

Per Diem-Based Network Providers: We pay transfer cases (into or out of the hospital) at the applicable medical or surgical per diem rate.

9.7 Readmissions: Inpatient Claims

UMP may review inpatient readmission for the same or a similar condition that occurs within 30 days of a previous discharge on a retrospective basis.

9.8 Outpatient Discounting Rules for Multiple Surgical Procedures

UMP applies Medicare's payment policy when processing multiple surgical procedures provided during the same operative session.

- The procedure with the highest weight value is priced based on 100 percent of the APC payment.
- Subsequent procedures are priced at 50 percent.

9.9 Outpatient Terminated Procedures

UMP will pay for surgical procedures terminated prior to anesthesia at 50 percent of the APC-based allowed charge.

9.10 AP-DRG and APC Grouping of Claims

UMP assigns the inpatient claim to an All-Patient Diagnosis Related Group (AP-DRG) during claims processing. The grouping and pricing methodology is based on patient discharge date. The rates and the weights in effect for the discharge period will apply. Outpatient hospital claims reimbursed under the Outpatient Prospective Payment System (OPPS) will be grouped to the appropriate APC based on service date. Hospitals are not required to group claims before submission.

Appendix 1

Corrected Claim — Standard Cover Sheet

Health Plan: _____ Product: _____

Attention: _____ Date cover sheet prepared: _____

➢ **This is NOT a DUPLICATE claim. Please forward to the appropriate area for reprocessing.**

Be sure to attach the updated claim form!

Claim Identification Information

Original Claim Number (from voucher): _____

Provider Office Contact Person

Name: _____ Phone Number: _____

Other Information: _____

This claim is a corrected billing of a previously processed claim for the following reason(s):

- ❑ Corrected diagnosis
- ❑ Corrected date of service
- ❑ Corrected charges
- ❑ Corrected patient information
- ❑ Other:
- ❑ Corrected procedure code (CPT or CM)
- ❑ Addition, or correction, of modifier
- ❑ Corrected provider information

Any specific clarification/comment/instructions (e.g., the claim line that was corrected):

Supporting Documentation Attached? ❑ Yes ❑ No

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Rev 3.6

Appendix 2: Detail of Remittance (DOR), Inpatient Hospital

UNIFORM MEDICAL PLAN PO BOX 34850 SEATTLE WA 98124-1850 TOLL FREE: 1-800-762-6004	HOSPITAL MEDICAL CENTER PO BOX 999999 SEATTLE WA 98124	SEE LAST PAGE FOR EXPLANATION OF CODE	PROV# :111111111 TAX ID#:111111111 DATE: 02/12/2007 DRAFT #: 00297980 ENVOY/NEIC ID# 75243

PATIENT NAME ACCOUNT#	BENEFIT ID# CLAIM#	APC	SVC DATE	REV/PROC CODE	#	BILL AMOUNT	ALLOWED AMOUNT	NONCOVD	CODE	DEDUCTIBLE AMOUNT	COPAY COINS	PPO DISCOUNT	PATIENT BALANCE	AMOUNT PAID
TEST PERSON 999999999	W999999999 K9999998-00													
			02/12/07		0	9,561.00	5,522.78	.00	PPU	.00	600.00	4,038.22	.00	4,922.78
			02/12/07	120	3	2,576.00			*RG					
			02/12/07	250	82	2,584.00			*RG					
			02/12/07	300	2	92.00			*RG					
			02/12/07	301	5	195.00			*RG					
			02/12/07	305	2	152.00			*RG					
			02/12/07	306	6	804.00			*RG					
			02/12/07	307	1	55.00			*RG					
			02/12/07	320	2	504.00			*RG					
			02/12/07	410	6	406.00			*RG					
			02/12/07	450	1	1,058.00			*RG					
			02/12/07	460	1	69.00			*RG					
			02/12/07	942	2	66.00			*RG					
		APDRG	436	CLAIM TOTAL		9,561.00	5,522.78	.00		.00	600.00	4,038.22	.00	4,922.78
													Payment	4,922.78

TOTAL PAID 4,922.78

Code Descriptions

****

PLEASE NOTE: THE ATTACHED DRAFT MAY INCLUDE BENEFIT PAYMENTS FOR MORE THAN ONE OF YOUR PATIENTS. PLEASE REFER TO THIS DETAIL OF REMITTANCE LISTIG TO ENSURE EACH OF YOUR PATIENTS IS CREDITED WITH THE CORRECT PAYMENT AMOUNT.

****

PPU THIS IS YOUR PLANS PARTICIPATING PROVIDERS CONTRACTUAL ALLOWANCE FOR THIS SERVICE. PROVIDER AGREES TO REDUCE THE FEE TO THE AMOUNT ALLOWED.

*RG TOTAL DRG ALLOWABLE IS ON THE FIRST LINE. CLAIMS >17 LINES ARE SEGMENTED. ADD FIRST LINE OF EACH SEGMENT FOR TOTAL DRG.

*** REQUESTS FOR RECONSIDERATION OF THE WAY A CLAIM WAS PROCESSED, TO INCLUDE BUNDLING, COB OR ALLOWABLE FEE ISSUES, SHOULD BE DIRECTED TO: UNIFORM MEDICAL PLAN, P.O. BOX 34578, SEATTLE, WA 98125-1578

Appendix 3: Detail of Remittance (DOR), Outpatient Hospital

UNIFORM MEDICAL PLAN PO BOX 34850 SEATTLE WA 98124-1850 TOLL FREE: 1-800-762-6004	HOSPITAL MEDICAL CENTER PO BOX 999999 SEATTLE WA 98124	SEE LAST PAGE FOR EXPLANATION OF CODE	PROV# :111111111 TAX ID#:111111111 DATE: 02/09/2007 DRAFT #: 00123456 ENVOY/NEIC ID# 75243

PATIENT NAME ACCOUNT#	BENEFIT ID# CLAIM#	APC	SVC DATE	REV/PROC CODE	#	BILL AMOUNT	ALLOWED AMOUNT	NONCOVD	CODE	DEDUCTIBLE AMOUNT	COPAY COINS	PPO DISCOUNT	PATIENT BALANCE	AMOUNT PAID
TEST PERSON 999999999	W999999999 K9999999-00													
			02/02/07	306 87070	1	77.00	77.00	.00		.00	7.70	.00	7.70	69.30
			02/02/07	306 87205	1	48.00	48.00	.00		.00	4.80	.00	4.80	43.20
			02/02/07	450 10060	1	215.00	215.11	.00	Z9 PPU	75.00	14.01	159.89	89.01	126.10
			02/02/07	450 99283 25	1	371.00	303.48	.00	PPU	.00	30.34	67.52	30.34	273.14
		APDRG		CLAIM TOTAL		871.00	643.59	.00		75.00	56.85	227.41	131.85	511.74
													Payment	511.74

TOTAL PAID 511.74

Code Descriptions

****

PLEASE NOTE: THE ATTACHED DRAFT MAY INCLUDE BENEFIT PAYMENTS FOR MORE THAN ONE OF YOUR PATIENTS. PLEASE REFER TO THIS DETAIL OF REMITTANCE LISTIG TO ENSURE EACH OF YOUR PATIENTS IS CREDITED WITH THE CORRECT PAYMENT AMOUNT.

****

Z9 THIS AMOUNT INCLUDES ALL OR PART OF THE PATIENTS EMERGENCY ROOM VISIT COPAY. THE EMERGENCY ROOM COPAY IS $75.00 FOR EACH VISIT.

PPU THIS IS YOUR PLANS PARTICIPATING PROVIDERS CONTRACTUAL ALLOWANCE FOR THIS SERVICE. PROVIDER AGREES TO REDUCE THE FEE TO THE AMOUNT ALLOWED.

*** REQUESTS FOR RECONSIDERATION OF THE WAY A CLAIM WAS PROCESSED, TO INCLUDE BUNDLING, COB OR ALLOWABLE FEE ISSUES, SHOULD BE DIRECTED TO: UNIFORM MEDICAL PLAN, P.O. BOX 34578, SEATTLE, WA 98125-1578